

## CERTIFICATE OF DEATH

03710

1. DECEASED-NAME (Type or print) <u>Franklin</u> <u>Phillip</u> <u>Barley</u>		2a. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>69</u>		2b. HOUR <u>8:05</u> P.M.
3. SEX <u>male</u>	4. RACE <u>white</u>	5. DATE OF BIRTH <u>01/01/94</u>	6. AGE (In years last birthday) <u>75</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>Indiana</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>CARROLL</u> Md.	
10. CITY OR TOWN OF DEATH <u>Sykesville</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Springfield State</u>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>construction wkr</u>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>	13b. CITY OR TOWN <u>Balto. City</u>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>3306 Rueckert Avenue</u>	
14. FATHER'S NAME First Middle Last <u>CHARLES</u> <u>BARLEY</u>	15. MOTHER'S MAIDEN NAME First Middle Last <u>NORA</u> <u>COON</u>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		
16b. SOCIAL SECURITY NO. <u>181-12-7924</u>	17. INFORMANT <u>Hospital Records</u> Address			
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Embolism in right pulmonary artery</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4123</u> yrs <u>min.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CBS associated with cerebral arteriosclerosis without qualifying phrase</u>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>2/17</u> , 19 <u>67</u> , to <u>3/20</u> , 19 <u>69</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>3/20</u> , 19 <u>69</u> and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.				
22b. SIGNATURE <u>FAYSA B. NAJJAR</u>	22c. DATE SIGNED <u>3/20/69</u>	22d. PHYSICIAN'S NAME (Type) <u>FAYSA B. NAJJAR</u>		
22e. ADDRESS <u>5501A SARRIL RD. BALTO, MD 21206</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>3/24/69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Leonard J Ruck Inc, Baltimore, Maryland</u>	25a. REC'D BY REGISTRAR <u>MAR 24 1969</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

08315

08315

RECEIVED

U.S. DEPARTMENT OF AGRICULTURE

Division of Plant Industry

Washington, D.C.

August 1, 1918

Dear Sir:

I have received your letter of July 1, 1918.

Very truly yours,

W. L. Rouse

Director

Division of Plant Industry

2

Very truly yours,

W. L. Rouse

Division of Plant Industry

August 1, 1918

Washington, D.C.

Very truly yours,

W. L. Rouse

August 1, 1918

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										03711					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03711					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year		2b. HOUR				
ROBERT MARTIN BEDWELL						3-31 1969			6:00 A.M.						
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			
MALE		WHITE		OCT. 11, 1916		52 YRS.		MONTHS DAYS		HOURS MIN.		Month 3 Day 31 Year 1969			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. COUNTY OF DEATH			
VIRGINIA			U.S.A.			WIDOWED			DIVORCED			CARROLL Co. MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)				12b. KIND OF BUSINESS OR INDUSTRY			
WESTMINSTER				CARROLL CO. GEN. HOSP. - CEMENT FINISHER											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
MARYLAND				CARROLL				WESTMINSTER				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME				First Middle Last				15. MOTHER'S MAIDEN NAME				First Middle Last			
JOHN				BEDWELL				BELL				MILLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
NO				166-12-5896				MRS VERDA @ BEDWELL				WESTMINSTER MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Coronary Thrombosis (acute)										Sudden					
DUE TO, OR AS A CONSEQUENCE OF										4100					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										years					
(b) Hypertension															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				HOUR A.M. P.M. 19											
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>												County			
												State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED							
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				3-31-69							
				DEPUTY MEDICAL EXAMINER											
				ADDRESS (Type)											
				135 E. Main, Westminister, Carroll											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)			
Burial				4/2/69				ST. MARY'S CEMETERY				SILVER RUN/CARROLL Co. MD.			
24. FUNERAL DIRECTOR				-ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
J. E. Myers, Jr., Westminister, Md.								APR 2 1969				J. Charles Jones			

2158

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

03717										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03712																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year																																																	
JAMES - BOOHER										MARCH 31 1969										7:20 P.M.																																							
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
M W										SEPT 30 - 1878										90										YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH										Md.																			
TENN. USA																				CARROLL																																							
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
RURAL UNION BRIDGE										MT UNION										FARMER										OWN FARM																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
MARYLAND										CARROLL										UNION BRIDGE										YES										MT UNION																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
First Middle Last										First Middle Last																																																	
BEN BOOHER										MARTHA CRUMLEY																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
NO										214-36-7681										ROXIE BOOHER										UNION BRIDGE MD																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART I. DEATH WAS CAUSED BY:																																																											
IMMEDIATE CAUSE (a) 4123										DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease										15 yrs.																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b) Generalized Arteriosclerosis										20 yrs.																																							
(c)																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																																																											
Osteoarthritis																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 8/21, 1947, to 3/31, 1969, that (I) (we) saw the deceased alive on 3/12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
R. S. McVaugh M.D.										1 Apr. 69																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
R. S. McVaugh M.D.										Taneytown, Maryland 21787																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
BURIAL										4/3/69										LUTHERAN										UNION TOWN MD																													
24. FUNERAL DIRECTOR										25a. REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																							
D.D. Hutzler & Sons Union Bridge										DATE APR 7 1969										Charles Judge																																							

CENTRAL INTELLIGENCE AGENCY

03717

TO : DIRECTOR, CENTRAL INTELLIGENCE AGENCY  
FROM : [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report body.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03718 CERTIFICATE OF DEATH 03713									
1. DECEASED-NAME (Type or print) Della F. Browning			First Middle Last			2a. DATE OF DEATH Month 3 Day 15 Year 69		2b. HOUR 7:35	
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 3, 1889		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pullen Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route 2	
14. FATHER'S NAME First Middle Last William Fleming			15. MOTHER'S MAIDEN NAME First Middle Last Lucretia Baker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219-36-0490B		17. INFORMANT Address Raymond A. Browning Same As #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic coma</u> <u>403X</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Nephro-sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks. 1 yr. 10 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Stroke. ASHD</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 11</u> , 19 <u>69</u> , to <u>Feb. 27</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Feb. 27</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Sani Okutman</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>3-17-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>Sani Okutman, M.D.</u>		22e. ADDRESS <u>Obrecht Rd., Sykesville, Md. 21784</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3/18/1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		23d. LOCATION (City or Town) (County) (State) <u>Mt. Airy, Carroll, Md.</u>			
24. FUNERAL DIRECTOR <u>C.M. Waltz</u>		ADDRESS <u>Box 241, Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 19 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12  
30  
4

2

1

03719

CERTIFICATE OF DEATH

03714

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR		
Alice Rebecca Carlisle						Month	Day	Year	1:00 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		
female		white		3-11-1880			88		MONTHS		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH			Md.	
Maryland		U.S.A.					Carroll				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville-rural			Springfield State Hosp.			NURSING			NORE HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			—			Baltimore				2707 N. Howard St.	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Benjamin						Mary					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
no			219-16-3969-A			Springfield Hospital			Sykesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchitis - PNEUMONIA</u> 427.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC OUTF.</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS. MOS.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town County State		
22a. I certify that (X) (this hospital) attended the deceased from 7-25, 19 67, to 3-8, 19 69, that (H) (we) lost saw the deceased alive on 3-8-1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Naci N. Buyukunsal, M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Naci N. Buyukunsal, M.D.						Springfield Hosp. Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			3-11-69			St. Mary's			Rakland Ave B216 MD		
24. FUNERAL DIRECTOR						ADDRESS			25a. RECEIVED BY REGISTRAR		
Burke Funeral Home Baltimore Md									MAR 11 1969		
									25b. REGISTRAR'S SIGNATURE		
									James Judge		

100-100000

01700



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03720				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03715			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR				
Gladys			Helen	Carlson	3 Month 17 Day 69 Year		12:15		am		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
female		white		12/27/92		76 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
California		USA				Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Rural--Sykesville		Springfield State Hospital		teacher							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Montgomery		Wash.D.C.				5215 Baltimore Avenue			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Franklin			C.	Freeman	Helen			?	Bassett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
no		220-54-6307		Springfield Hospital records, Sykesville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia.</u> 481X DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <del>it</del> (this hospital) attended the deceased from <u>7/17/</u> , 19 <u>64</u> , to <u>3/17/</u> , 19 <u>69</u> , that <del>it</del> (we) last saw the deceased alive on <u>3/17/</u> , 19 <u>69</u> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) (not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
Edmee J. Reeves		3/17/69		Edmee J. Reeves, M. D.		Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		3-20-69		Parklawn Cemetery		Rockville, Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
ROBERT A. PUMPHREY, Bethesda, Maryland				MAR 24 1969		Charles Judge					

08780

RECEIVED BY THE DIRECTOR, FBI, WASHINGTON, D.C.

URGENT 10-10-54

08780

TO DIRECTOR, FBI, WASHINGTON, D.C. FROM SAC, NEW YORK (100-100000) (P)

RE NEW YORK TELETYPE TO BUREAU, OCTOBER NINE LAST, AND BUREAU TELETYPE TO NEW YORK, OCTOBER TEN LAST.

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RE NEW YORK TELETYPE TO BUREAU, OCTOBER NINE LAST, AND BUREAU TELETYPE TO NEW YORK, OCTOBER TEN LAST.

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03721

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05249

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month		Day		Year		2b. HOUR			
JOSEPH JOHN CHAMBERS										3-31		1969				1500 M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year			
male	white	2-15-12		59 YRS		MONTHS		DAYS		3		31		1969		1500 M			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH											
Maryland		U.S.A.						Carroll											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY							
Sykesville				Springfield State Hospital				Laborer											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Maryland				Howard		Ellicott City		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8202 Maryland Ave.									
14. FATHER'S NAME				First		Middle		Last		15. MOTHER'S MAIDEN NAME				First		Middle		Last	
Matthew Chambers										Cecilia Riley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS									
yes				215-05-7887		Springfield State Hospital Records													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute purulent meningitis- organism to be</u> <u>485X</u> DUE TO, OR AS A CONSEQUENCE OF <u>determined</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) <u>Bronchopneumonia</u>																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
																Days			
																Days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Alcoholism</u>																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?											
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
				19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				W. Glenn Speicher, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
								ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				3-31-69							
EXAMINER'S NAME (Type)								DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				135 E. Main St. Carroll Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)									
Burial				3-3-69		St Johns				Ellicott City Md.									
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Higginbottom Slack				Ellicott City, Md.				APR 9 1969				Charles Judge							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03722

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03716

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M	
James			Walter	Christopher	3- 20 1969					
3. SEX male		4. RACE white		5. DATE OF BIRTH 5 - 20 - 02		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Carroll				Md.
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) carpenter		12b. KIND OF BUSINESS OR INDUSTRY retired				
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3510 Hayward Ave.		
14. FATHER'S NAME William N. Christopher			First	Middle	Last	15. MOTHER'S MAIDEN NAME Carrie Respass				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) no		16b. SOCIAL SECURITY NO. 218 - 12 - 8798A		17. INFORMANT Hospital Records Springfield Hospital		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Severe arteriolar nephrosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from 2 - 20 - 1969, to 3 - 20 - 1969, that (I) (we) last saw the deceased alive on 3 - 20 - 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Glocrito G. Sagisi					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-20-69			
22d. PHYSICIAN'S NAME (Type) Glocrito G. Sagisi, M. D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/22/69.		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) Baltimore, Md.		(County)		(State)
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214					25a. REC'D BY REGISTRAR DATE MAR 24 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

SSCEC

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03723									
03717									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last Joseph Edward Cook					Man Month 8 Day 1969 Year			8 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		March 28, 1896		72 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll Co. Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll Co. Gen. Hosp. Service Man		Propene Gas					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore		Reisterstown				21 Stocksdales Avenue	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Ernest L. Cook			Amelia Jane Berryman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No		441-10-9899		Jessie M. Cook 21 Stocksdales Ave. Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Atherosclerotic Cardiovascular Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Uremia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 20, 1969</u> , to <u>Mar 8, 1969</u> , that (I) (we) last saw the deceased alive on <u>Mar 6, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>John S. Harshey, MD</u>		<u>3/8/69</u>							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
JOHN S. HARSHEY, MD		8 Anchor St. Westminster Md. 21157							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Mar. 11, 1969		Reisterstown Meth. Cem. Reisterstown, Balto., Md.					
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
<u>H. J. Eckhardt</u> Owings Mills, Md.				MAR 10 1969		<u>Charles Judge</u>			

03752

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03724										
03718										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR A.M.		
REGINA			JANE			COUNIHAN		March 7, 1969 9:05 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
Female		White		11-27-84		84 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Carroll Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			Housewife				
13a. USUAL RESIDENCE (Where deceased lived or admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Allegany		Cumberland		YES		229 Union Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
William			Mattingly			Mary Ann Coyne				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address				
No			214-05-8784-R			Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-13-68</u> , 19____, to <u>3-7-69</u> , 19____, that (I) (we) lost saw the deceased alive on <u>3-7-69</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dr. Antonius Glahn</u>					22c. DATE SIGNED 3/7/69		22d. PHYSICIAN'S NAME (Type)			
Antonijs Glahn, M.D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		3/10/69		St. Patrick's Cemetery		Cumberland Allegany Maryland				
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Silcox-Merritt Funeral Service Cumberland, Md				21502		MAR 11 1969				

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR-
Baby Boy Cowgill						Month	Day	Year	9:20 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		white		March 30, 1969		YRS.		MONTHS	DAYS
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll County Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster			Carroll County General			---		---	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
Md			Carroll		Finksburg		Christiana Apts.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
Jerry Dale Cowgill						Linda Lou Metz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Immaturity Twin Boy</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>7694</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>2-30, 1969</u> , to <u>2-30, 1969</u> , that (I) (we) last saw the deceased alive on <u>2-30, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2/30/69</u>		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
removal		3/31/69							
24. FUNERAL DIRECTOR'S NAME (Type)					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Glenn A. Fisher					<u>[Signature]</u>		APR 7 1969		<u>[Signature]</u>

03752

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

TO THE SECRETARY, U. S. DEPARTMENT OF AGRICULTURE  
FROM THE DIRECTOR, U. S. BUREAU OF PLANT INDUSTRIES  
SUBJECT: [Illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing agricultural matters, possibly related to plant industries or pest control.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03726			03720								
1. DECEASED-NAME (Type or print) <b>Baby Girl Cowgill</b>			2a. DATE OF DEATH Month <b>3</b> Day <b>30</b> Year <b>1969</b>			2b. HOUR <b>5:08</b> M					
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>March 30, 1969</b>		6. AGE (In years last birthday) YRS. <b>---</b>		IF UNDER 1 YEAR MONTHS <b>---</b> DAYS <b>---</b>		IF UNDER 24 HRS. HOURS <b>12</b> MIN <b>13</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll County</b> Md.					
10. CITY OR TOWN OF DEATH <b>Westminster</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll County General</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>---</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Finksburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Christiana Apts.</b>		
14. FATHER'S NAME First <b>Jerry</b> Middle <b>Dale</b> Last <b>Cowgill</b>			15. MOTHER'S MAIDEN NAME First <b>Linda</b> Middle <b>Lou</b> Last <b>Metz</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7777X Immobility - Twin 1'14"</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>---</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>3-30, 1969</b> , to <b>3-30, 1969</b> , that (I) (we) lost the deceased alive on <b>3-30, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Karl M. Green, M.D.</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3/30/69</b>			
22d. PHYSICIAN'S NAME (Type) <b>Karl M. Green, M.D.</b>						22e. ADDRESS <b>Westminster, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>			23b. DATE <b>3/31/69</b>		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>Glenn A. Fisher</b>						ADDRESS <b>---</b>		25a. REC'D BY REGISTRAR DATE <b>APR 7 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03721			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										03721			
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year		2b. HOUR		
JAMES LEONARD COX						3-20 1969			A		M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male		Negro		6-9-1900		68 YRS.		MONTHS DAYS		HOURS MIN		Month 3 Day 20 Year 1969	
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. COUNTY OF DEATH	
North Carolina			U.S.A.			WIDOWED			DIVORCED			Carroll Md.	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville				Springfield State Hospital				Retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland						Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1908 Eutaw Place	
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last				
Leonard			Cox			Lisa							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS	
No				577-16-9427				Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u>										years			
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) <u>Pulmonary T.B. (arrested)</u>										years			
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
CAUSE OF DEATH				HOUR A.M. P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				City or Town County State	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED					
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				3-20-69					
W. Glenn Speicher, M. D.				DEPUTY MEDICAL EXAMINER				3-20-69					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County)			
Burial				3/22/69		Mt. Calvary Cem.				Baltimore Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR						25b. REGISTRAR'S SIGNATURE	
J.B. Johnson 1900 Eutaw Pl. Balt. Md.						MAR 26 1969						J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03728		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03722					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Vernon		Sylvester		Dolan				Month 3 Day 25 Year 69		2:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		7-4-97		71 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Maryland		U.S.A.				Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Sykesville		Springfield State Hosp.		Retired							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Allegany		Oldtown				R#1			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Alexander Dolan 'dec.)								Verde Rice (dec)			
16a. WAS DECEASED EVER Yes, no, or unknown		IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no				232-1045637-A		Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pyelonephritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days months years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (1) (this hospital) attended the deceased from <u>3-21</u> , 19 <u>69</u> , to <u>3-25-69</u> , 19 <u>  </u> , that (1) (we) last saw the deceased alive on <u>3-25-69</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <u>not</u> view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
Suha Ozgun		3-25-69									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Suha Ozgun		Springfield State Hospital Sykesville Md.									
23a. BURIAL, CREMATION, REMOVING BODY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		3/28/1969		Davis Memorial Park		Near Cumberland Alleg				Md.	
24. FUNERAL DIRECTOR		24a. ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John J. Hafer, Jr.		230 Balto Ave Cumberland Md.		MAR 27 1969		William Judge					

23750

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-59

03729		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03723	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last JASPER HENRY DULL			2a. DATE OF DEATH Month 6 Day 19 Year 1969			2b. HOUR 2:40 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH OCT. 19, 1912		6. AGE (In years last birthday) 56 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Co.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL Co. GEN. HOSP. CONTRACTOR AND BUILDER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER REESE		14. FATHER'S NAME First Middle Last EMANUEL J. DULL		15. MOTHER'S MAIDEN NAME First Middle Last DAISY MAY BLOOM			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO		16b. SOCIAL SECURITY NO. 216-07-4373		17. INFORMANT Address MRS. VIVIAN G. DULL, WESTMINSTER RD #4 2nd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 428X Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocarditis DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Mar 2, 1969, to Mar 6, 1969, that (I) (we) last saw the deceased alive on Mar 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John S. Harshey, MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/6/69	
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, MD		22e. ADDRESS 8 Sanchez St. Westminster, Md.					
23a. BURIAL-CREMATATION, REMOVAL (Specify) Burial		23b. DATE 3/9/69		23c. NAME OF CEMETERY OR CREMATORY ZION METH-CEMETERY		23d. LOCATION (City or Town) (County) (State) WESTMINSTER RD, MD	
24. FUNERAL DIRECTOR J. S. Myers, Jr., Westminster, Md.		ADDRESS		25a. REC'D BY REGISTRAR MAR 10 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

03380

STATE OF TEXAS

COUNTY OF DALLAS

03380

03380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03730

CERTIFICATE OF DEATH

03724

1. DECEASED-NAME (Type or print) <b>JULIA</b> First <b>KATHERINE</b> Middle <b>DUVALL</b> Last			2a. DATE OF DEATH <b>MAR</b> Month <b>22</b> Day <b>1969</b> Year		2b. HOUR <b>2:30</b> PM
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>FEB 21 1902</b>		6. AGE (In years lost birthday) <b>67</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>CARROLL</b> Md.		
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ROUTE #1</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>CARROLL</b>	13c. CITY OR TOWN <b>NEW WINDSOR</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <b>ROUTE #1</b>	
14. FATHER'S NAME First Middle Last <b>REUBEN SIDNEY BAKER</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY CATHERINE PORTER</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <b>215-14-1634</b>	17. INFORMANT <b>IRVIAN MYERS</b> Address <b>ROUTE 1 Westminster, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG.</b> APPROX 6 MO. <b>1621</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>OCTOBER 1967</b> , to <b>MARCH 1969</b> , that (I) (we) last saw the deceased alive on <b>MARCH 22 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Daniel I. Welliver MD</b> DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>3-22-69</b>			
22d. PHYSICIAN'S NAME (Type) <b>DANIEL I. WELLIVER MD.</b>	22e. ADDRESS <b>WESTMINSTER, MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/25/1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethany Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Carroll, Md.</b>		
24. FUNERAL DIRECTOR <b>C.M. Waltz, Box 241, Sykesville, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>MAR 26 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>		

03730



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03731

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03725

1. DECEASED-NAME (Type or Print)			First Middle Last <b>JEAN PORTER EDWARDS</b>			2a. DATE KNOWN OF DEATH Month Day Year <b>3-31 1969</b>			2b. HOUR M <b>4:15</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9-4-15</b>		6. AGE (In years last birthday) <b>53</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>3 31</b>		IF UNDER 24 HRS HOURS MIN. <b>3 31</b>			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll</b>				
10. CITY OR TOWN OF DEATH <b>Sykesville</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Social worker</b>				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>				13b. COUNTY <b>City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2338N. Calvert St.</b>			
14. FATHER'S NAME First Middle Last <b>Harry P. Porter, Sr.</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Ethel Bagley</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-20-6753</b>			17. INFORMANT ADDRESS <b>Springfield State Hosp. Records Sykesville MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangulation by hanging</b> <b>953X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Manic Depressive reaction, Manic type</b>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>3-31 1969 7 P.M.</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Fell backward off chair, head struck floor, fractured skull</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Both Room 2nd floor Carroll County Courthouse</b>				21f. LOCATION Street or R.F.D. No. <b>2 Springfield Station</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>3-31-69</b>					
EXAMINER'S NAME (Type) <b>W. Glenn Speicher M. D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, State) <b>135 E. Main Westminister Carroll</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>4-3-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Chapel</b>			23d. LOCATION (City or Town) (County) (State) <b>Wilna Harford Md.</b>			25a. REC'D BY REGISTRAR DATE <b>APR 2 1969</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>							25b. REGISTRAR'S SIGNATURE <b>Richard J. Ruck</b>						

08331

RECEIVED AMERICAN LEGATION OF LONDON

TELETYPE UNIT  
EDWARDS

FOR INFO  
RECEIVED

[Faint, mostly illegible teletype text follows, appearing to be a message body with several lines of communication.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03732

Item#5&amp;6, FilmG411 4/7/69 km

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03726

1. DECEASED-NAME (Type or print) First Middle Last MAY AUGUSTA EYLER			2a. DATE OF DEATH Month Day Year 3-31-1969			2b. HOUR 4:30 PM						
3. SEX Female		4. RACE White		5. DATE OF BIRTH 10 5/11/1914		6. AGE (In years last birthday) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.						
10. CITY OR TOWN OF DEATH SYKESVILLE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRINGFIELD STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY OR TOWN BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3509 HAYWARD AVE.					
14. FATHER'S NAME First Middle Last William P. Rustic			15. MOTHER'S MAIDEN NAME First Middle Last MARY E. Coleman			Address S.S. HOSPITAL Sykesville, MD						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 212-22-2649			17. INFORMANT HOSPITAL RECORDS			Address Sykesville, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4124 DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF (a) _____ (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CBS associated with cerebral arteriosclerosis</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>7/27, 1964</u> to <u>3/31, 1969</u> that (I) (we) last saw the deceased alive on <u>3/31, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>R. G. Latochere MD</u> DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3/31/1969</u>				
22d. PHYSICIAN'S NAME (Type) <u>RINALDO G. LATOCHERE MD</u>						22e. ADDRESS <u>SPRINGFIELD STATE HOSPITAL SYKESVILLE, MD.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>4/3/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Pikesville Maryland</u>				
24. FUNERAL DIRECTOR <u>Loring Byers Chapel 8728 Liberty Road 21133</u>						25a. REC'D BY REGISTRAR <u>APR 2 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

SECRET

SECRET

OFFICE OF THE DIRECTOR, NATIONAL SECURITY AGENCY

MEMORANDUM FOR THE DIRECTOR

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03733

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03727

1. DECEASED-NAME (Type or Print) First Middle Last <b>EDGAR RICKEY FEW</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year <b>3-16 1969</b>			2b. HOUR <b>4:30 A M</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Aug 20, 1950</b>	6. AGE (in years last birthday) <b>18</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS <b>18</b>	IF UNDER 24 HRS. HOURS MIN <b>18</b>	2c. DATE PRONOUNCED DEAD Month Day Year <b>3 16 1969</b>	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b>	
10. CITY OR TOWN OF DEATH <b>Union Bridge</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>-</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Marriottsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last <b>Howard - Few</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Dorothy - Mirfin</b>			13e. STREET AND NUMBER <b>Marriottsville Road</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Vivian Few</b>		
16c. ADDRESS <b>Mariottsville, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shotgun wound upper left chest</b> 92229 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year <b>2:00 P.M. 3-16-69</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 18 or Part 21b) <b>Wife was trying to get shotgun out of car from back and 9 gun went off</b>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, hospital, factory, office building, etc.) <b>Rear of 169 W Main</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>Rear 169 W Main Westminster Carroll Ind.</b>			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>3-16-69</b>	
EXAMINER'S NAME (Type) <b>W. Glenn Speicher</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS <b>135 S. Main Westminster Ind</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-18-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Freedom Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Lysaeville Md Carroll Ind</b>	
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>			ADDRESS <b>Lysaeville, Md.</b>			25a. REC'D BY REGISTRAR <b>20 MAR 20 1969</b>	
			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				

03333



*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03734									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Anna Estella Filsinger						3 Month 15 Day 69 Year		2:10 a	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		II-15-93		75 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Maryland		U.S.A				Carroll			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Rural Sykesville		Springfield State Hospital		House wife		OWN HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Allegheny		Frostburg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Route #1 Box 610	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Emanuel --- Porter			Frances Porter						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
no			214-OI-3596-y			Springfield Hospital Records Sykesville Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Urinary Tract Infection And Multiple Bed Sores</u> <u>4124</u> <u>Weeks</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Arteriosclerotic . C.V.D.</u> <u>Years</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>1-15</u> , 19 <u>69</u> , to <u>3-15</u> , 19 <u>69</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Antonius Glahn</u> DEGREE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>3-15-69</u>		
22d. PHYSICIAN'S NAME (Type) <u>Antonius Glahn M.D.</u>					22e. ADDRESS <u>Springfield State Hospital</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		<u>3-18-69</u>		ECKHART CEMETERY		ECKHART, ALLEGANY, MD.			
24. FUNERAL DIRECTOR <u>MariLou Mowers</u>		ADDRESS <u>60 W. Main St. Frostburg Md.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>MAR 20 1969</u>									

03334

UNITED STATES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
30M REV. 1-68

03735		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21200				3729		550 PM			
1. DECEASED-NAME (Type or print) First Middle Last RAYMO MILTON FOGLE						2a. DATE OF DEATH Month Day Year 3 22 69				2b. HOUR MIN.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 8/2/1911		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL				Md.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO GEN HOSP		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY MILK					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. CITY OR TOWN CARROLL		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER UNION BRIDGE		13e. STREET AND NUMBER ROUTE I			
14. FATHER'S NAME First Middle Last D. ODEN FOGLE		15. MOTHER'S MAIDEN NAME First Middle Last SUSAN WARNER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. No		17. INFORMANT DOROTHY B. FOGLE		Address UNION BRIDGE		City RF MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy and atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sept 1968</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/22</u> , 19 <u>69</u> , to <u>3/22</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>3/22</u> , 19 <u>69</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard Y. Dalrymple M.D.		22c. DATE SIGNED 3/23/69		22d. PHYSICIAN'S NAME (Type) RICHARD Y. DALRYMPLE		22e. ADDRESS 187 E. Main		22f. CITY WESTMINSTER, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/25/69		23c. NAME OF CEMETERY OR CREMATORY METHODIST CEM.		23d. LOCATION (City or Town) (County) (State) MIDDLEBURG, MD		23e. REC'D BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR R. A. Smith		24a. ADDRESS UNION BRIDGE MD		24b. DATE MAR 26 1969		24c. REGISTRAR'S SIGNATURE John...					

SALES

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										03730	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03730	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
GEORGE EDWARD GARLAND						MARCH 16 1969			1:45 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	Oct. 13, 1933	35 YRS.	MONTHS	DAYS	HOURS	MIN.	Month 3 Day 16 Year 1969	2:15 A.M.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Mitchell N.C.		USA				Carroll					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Hampstead			RD			Equipment Operator					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			Carroll			Westminster			RD		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Cart Garland			Mary Edwards								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
NO			242-44-3106			Cart Garland Rt. 1			Bakersville, N.C.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Skull &amp; Multiple Injuries</u> DUE TO, OR AS A CONSEQUENCE OF 8169										Sudden	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____ DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2, Item 18)			
CAUSE OF DEATH				1:45 P.M. 3-16-69				Car Ran off road struck Electric pole			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		State			
		Route 482		Route 482 1/2 mi. west		Hampstead		Md			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER				22b. DATE SIGNED					
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER				3-16-69					
W. Glenn Peicher		DEPUTY MEDICAL EXAMINER				155 E. Westminster		Carroll Md			
		23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County)	
Burial		March 18, 1969		Green Cemetery		RD Bakersville, N.C.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Henline & Hughes Funeral Home Bakersville, N.C.						MAR 20 1969		R. Charles Judge			

03730

UNITED STATES DEPARTMENT OF AGRICULTURE

For

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FOR STATE  
HEALTH DEPT.

03737

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03731

1. DECEASED-NAME (Type or Print) <b>JERRY WADE GARLAND</b>			First Middle Last			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>3</b> Day <b>16</b> Year <b>1969</b>			2b. HOUR <b>11:45</b> AM		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Nov. 25, 1939</b>	6. AGE (In years last birthday) <b>29</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <b>3</b> Day <b>16</b> Year <b>1969</b>			2d. HOUR <b>2:15</b> AM		
7a. BIRTHPLACE (State or foreign country) <b>N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>					
10. CITY OR TOWN OF DEATH <b>Hampstead</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RD.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Tree Trimmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Co.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Manchester</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rt. 1</b>		
14. FATHER'S NAME First <b>Arthur</b> Middle <b>Garland</b> Last			15. MOTHER'S MAIDEN NAME First <b>Dora</b> Middle <b>Igram</b> Last								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Velma Garland</b>			ADDRESS <b>Rt. 1 Manchester, Md.</b>		
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Skull &amp; Multiple Fractures</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>1:40 P.M. 3-16-69</b>				21c. HOW INJURY OCCURRED (Enter signature of injury in Part 2 of Report 18.) <b>Car ran off road struck Electric Pole</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Route 482</b>		21f. LOCATION Street or R.F.D. No. City or Town State <b>Route 482 1/2 mi West Hampstead Md Carroll County Md</b>							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Underdetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>E. E. Leiner</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>3-16-69</b>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, City, State) <b>135 E. Main St. Westminster Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)			
<b>Burial</b>		<b>March 19, 1969</b>		<b>Immanuel Cemetery</b>				<b>Manchester, Md.</b>			
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>MAR 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

081737

DECK V. WARD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-65

03738										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03732									
1. DECEASED-NAME (Type or print) First Middle Last										2a. DATE OF DEATH Month Day Year										2b. HOUR									
Edith S. George										March 16 1969										10:40 M									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.														
female			white			1-17-93			76 YRS.			MONTHS DAYS			HOURS MIN.														
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																				
MARYLAND			USA						Carroll						Md.														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY																				
Manchester			Kingsview Home			Housewife																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER																	
Md			Carroll			Westminster						118 Willis St.																	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last																										
Joseph M Simms			Mary Coalgaender																										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			Address																				
No			215-58-3685			Mrs Matilda Bone			118 Willis St Westminster, Md																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART I. DEATH WAS CAUSED BY:																													
IMMEDIATE CAUSE (a) 1579 Carcinoma of Pancreas										5 MON																			
DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																													
DUE TO, OR AS A CONSEQUENCE OF																													
(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 11/17/69, to 3/16/69, that (I) (we) last saw the deceased alive on 3/14/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.																													
22b. SIGNATURE W H Foard MD										22c. DATE SIGNED 3/16/69																			
22d. PHYSICIAN'S NAME (Type) W. H. Foard M.D.										22e. ADDRESS Manchester, Md 21102																			
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE 3/20/69					23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery					23d. LOCATION (City or Town) (County) (State) Longview Belts Co. Md.														
24. FUNERAL DIRECTOR J. S. Smyre, Jr., Westminster, Md					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE																			
										MAR 19 1969																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03739

CERTIFICATE OF DEATH

03733

1. DECEASED-NAME (Type or print) <b>EFFIE PAULINE GLOVER</b>			2a. DATE OF DEATH Month <b>3</b> Day <b>14</b> Year <b>69</b>			2b. HOUR <b>5<sup>30</sup> A</b> M						
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>SEPT. 20, 1894</b>		6. AGE (In years lost birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b> Md.						
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL G. GEN. HOSP. HOUSE - WIFE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b> COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <b>45 HOOK ROAD</b>						
14. FATHER'S NAME First <b>WALTER</b> Middle <b>DUVALL</b> Last <b>GILBERT</b>		15. MOTHER'S MAIDEN NAME First <b>ELLA</b> Middle <b>GILBERT</b> Last <b>GILBERT</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-12-7154</b>		17. INFORMANT <b>C. HERMAN GLOVER</b>		Address <b>11 N. COLONIAL AVE WESTMINSTER, MD</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4122</b> IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> YRS. DUE TO, OR AS A CONSEQUENCE OF (c) <b>40 HRS</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>3/12</b> , 19 <b>69</b> , to <b>3/14</b> , 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>3/14</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Thurmont J. Kneec. J MD</b>						22c. DATE SIGNED <b>3/14/69</b>			22d. PHYSICIAN'S NAME (Type)			
22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>3/17/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>DEER PARK CEMETERY SMALLWOOD, CARROLL, MD</b>			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <b>J. S. Smyers, Jr. Westminster, Md</b>						25a. REC'D BY REGISTRAR <b>MAR 17 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03740										
CERTIFICATE OF DEATH										
03734										
1. DECEASED-NAME (Type or print) <b>CLARK Louis HALL</b>					2a. DATE OF DEATH Month <b>3</b> Day <b>13</b> Year <b>69</b>			2b. HOUR <b>9<sup>35</sup> P</b>		
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 31, 1926</b>		6. AGE (In years last birthday) <b>42</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b>				
10. CITY OR TOWN OF DEATH <b>Westminster</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL Co. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LANDSCAPER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Landscaping</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md.</b>			13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Long Meadow Drive</b>	
14. FATHER'S NAME First <b>Charles</b> Middle <b>L.</b> Last <b>HALL</b>			15. MOTHER'S MAIDEN NAME First <b>Viola</b> Middle <b></b> Last <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW II</b>			16b. SOCIAL SECURITY NO. <b>219 20 0567</b>		17. INFORMANT <b>MRS. MARY E. HALL</b>		Address <b>Sykesville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHEROSCLEROTIC CORONARY HEART DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMED.</b> <b>DAYS</b> <b>YEARS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>3/10</b> , 1969, to <b>3/13</b> , 1969, that (I) (we) lost the deceased alive on <b>3/13</b> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Vincent J. Ficcoro Jr. MD</b>					22c. DATE SIGNED <b>3/13/69</b>		22d. PHYSICIAN'S NAME (Type) <b>Vincent J. Ficcoro Jr. MD</b>			
22e. ADDRESS <b>Westminster, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-17-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial</b>		23d. LOCATION (City or Town) (County) (State) <b>Westminster Carroll Md.</b>				
24. FUNERAL DIRECTOR <b>Nancy W. Haight Sykesville, Md.</b>					25a. REC'D BY REGISTRAR <b>18 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Nancy W. Haight</b>			

03740

STATEMENT OF DEATH

DEPARTMENT OF HEALTH, NEW YORK CITY

1934

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03741

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03735

1. DECEASED-NAME (Type or print) <i>Cora</i>		First	Middle	Last	2a. DATE OF DEATH Month <i>MARCH</i> Day <i>9</i> Year <i>1969</i>		2b. HOUR <i>4:15</i> M					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>December 20, 1893</i>		6. AGE (In years last birthday) <i>75</i> YRS.		IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Balto. Co. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i>			Md.			
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carroll Co. General Hospt.</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life; even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Greenmount</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
14. FATHER'S NAME First <i>Thomas</i> Middle Last <i>Smith</i>		15. MOTHER'S MAIDEN NAME First <i>Ida</i> Middle Last <i>Shearer</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown		16b. SOCIAL SECURITY NO. <i>216-36-5616</i>		17. INFORMANT <i>Mr. William E. Harris</i> Address <i>Greenmount, Md.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>4123</i> IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>FEB 25, 1969</i> , to <i>MAR 9, 1969</i> , that (I) (we) last saw the deceased alive on <i>MAR 9, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>John S. Harshey, MD</i>		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/9/69</i>				
22d. PHYSICIAN'S NAME (Type) <i>JOHN S. HARSHEY MD</i>		22e. ADDRESS <i>8 Archer St. Westminster, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>March 12, 69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Peters Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Co. Md.</i>						
24. FUNERAL DIRECTOR <i>Tipton-Eline Funeral Home</i>		ADDRESS <i>Hampstead, Md.</i>		25a. REC'D BY REGISTRAR <i>MAR 11 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03742									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
JEWEL			BERTHA HEINE			March 18, 1969			PM 11:40
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR	
Female		White		1-25-1892		77 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
District of Columbia		U.S.A.				Carroll Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield State Hospital		Clerk					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Montgomery		Silver Spring		311 Lanark Way			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Henry			Ansley			Nomie Marsh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		215-46-2416		Fred W. Heine, III		9705 Southland Rd., Sil.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									Days
IMMEDIATE CAUSE (a) Septicemia due to gram negative bacillus									
DUE TO, OR AS A CONSEQUENCE OF									Weeks
(b) Empyema of gallbladder									
DUE TO, OR AS A CONSEQUENCE OF									Days
(c) Agranulocytosis									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-27-69, 19__, to 3-18-69, 19__, that (I) (we) last saw the deceased alive on 3-18-69, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
Dr. Antonius Glahn								3/19/69	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Antonius Glahn, M. D.		Springfield State Hospital							
		Sykesville, Maryland 21784							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		March 22, 1969		Gate of Heaven Cemetery		Silver Spring Mont., Maryland			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc.		8434 Georgia Avenue Silver Spring, Md.		MAR 24 1969		Charles Judge			

MEDICAL CERTIFICATION

8345

VERIFICATION OF DEATH

1-2-1992

WATER

1-2-1992

1-2-1992

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03743					03737				
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Michael Joseph Hogan Jr.</b>					2a. DATE OF DEATH <b>March 16, 1969</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>March 16, 1969</b>		6. AGE (In years lost birthday) <b>YRS.</b>		2b. HOUR <b>7:08 P M</b>	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN <b>13</b>	
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Co. Hospt.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Hampstead</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rt. 2</b>	
14. FATHER'S NAME First Middle Last <b>Michael Joseph Hogan Sr.</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Lillian Louise Gunther</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Michael J. Hogan Rt. 2 Hampstead, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>7701 Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Alcoholism</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)				
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>3-16, 1969</b> , to <b>3-16, 1969</b> , that (I) (we) last saw the deceased alive on <b>3-16, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Eline Tipton</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 17, 1969</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Tipton - Eline Funeral Home Hampstead, Md.</b>					25a. REC'D BY REGISTRAR <b>MAR 20 1969</b>		25b. REGISTRAR'S SIGNATURE <b>V. Charles</b>		



03744

## CERTIFICATE OF DEATH

03738

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR			
Frederick			M.		Kaelber	Month 3 Day 16 Year 69			3:37 PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		White		Sept. 29, 1904		64 YRS.		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH						
Maryland		U.S.A.				Carroll Md.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Westminster			Carroll County Gen. Hosp.			Cashier			Race Track			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Baltimore			Reisterstown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Church Road		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
George					Kaelber	Anna					Borleis	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT						
No			265-09-0261			Mrs. Alma Kaelber, Church Road, Reisterstown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF LUNG												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from 3/9, 1969, to 3/16, 1969, that (I) (we) lost saw the deceased alive on 3/16, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE						22c. DATE SIGNED						
J. J. Schhardt						3/16/69						
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)		
Burial			Mar. 19, 1969		Woodlawn Cemetery		Woodlawn, Balto. Co., Md.					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
H. J. Schhardt			Owings Mills, Md.			MAR 19 1969		J. J. Schhardt				

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03324

CONFIDENTIAL

03324

1. NAME (Last, First, Middle)		2. DATE OF BIRTH		3. SEX	
4. ADDRESS (Street, City, State, Zip)		5. OCCUPATION		6. EDUCATION	
7. MARITAL STATUS		8. RELIGION		9. RACE	
10. POLITICAL AFFILIATION		11. SOCIAL SECURITY NUMBER		12. FINGERPRINTS	
13. SIGNATURE		14. DATE		15. OFFICIAL USE	

5

1

03745

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03739

1. DECEASED-NAME (Type or print) First Middle Last  
LESLIE ROY LAMBERT SR

2a. DATE OF DEATH Month Day Year  
Mar. 27 1949

2b. HOUR  
5:30 A.M.

3. SEX  
M

4. RACE  
W

5. DATE OF BIRTH  
JUNE 4 - 1883

6. AGE (In years last birthday)  
85 YRS.

IF UNDER 1 YEAR MONTHS DAYS  
IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (State or foreign country)  
MARYLAND

7b. CITIZEN OF WHAT COUNTRY?  
USA

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH  
CARROLL MD.

10. CITY OR TOWN OF DEATH  
WESTMINSTER

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  
327 E MAIN ST

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  
FARMER

12b. KIND OF BUSINESS OR INDUSTRY  
OWN FARM

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  
MARYLAND

13b. COUNTY  
CARROLL

13c. CITY OR TOWN  
WESTMINSTER

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET AND NUMBER  
327 E MAIN ST

14. FATHER'S NAME First Middle Last  
JOHN T LAMBERT

15. MOTHER'S MAIDEN NAME First Middle Last  
HENRIETTA STEVENSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)  
NO

16b. SOCIAL SECURITY NO.  
213-36-9379

17. INFORMANT Address  
HENRIETTA LAMBERT WESTMINSTER MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 4124 Arteriosclerotic C.V.D.  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) DUE TO, OR AS A CONSEQUENCE OF  
(c)  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 1960, 19, to 3/27/49, 19, that (I) (we) saw the deceased alive on 3/24/49, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE  
M.E. Robertson MD DEGREE

22c. DATE SIGNED  
3/27/1949

22d. PHYSICIAN'S NAME (Type)  
ME ROBERTSON

22e. ADDRESS  
New Windsor, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)  
BURIAL

23b. DATE  
3/30/69

23c. NAME OF CEMETERY OR CREMATORY  
PIPE CREEK

23d. LOCATION (City or Town) (County) (State)  
NEW WINDSOR MD

24. FUNERAL DIRECTOR ADDRESS  
D.D. Hertzler & Sons New Windsor

25a. REC'D BY REGISTRAR  
MAR 28 1969

25b. REGISTRAR'S SIGNATURE  
Charles Judge

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VR A15 1-68  
30M REV. 1-68

03742

EXPERIMENT 9 - 1941

03740



03746

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Katherine			Ellen	Larrimore	3 Month 12 Day 69 Year			9:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
female		white		3/29/95		73 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Maryland		USA				Carroll					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Rural--Sykesville			Springfield State Hospital			none					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Frederick			Walkersville		YES <input type="checkbox"/> NO <input type="checkbox"/>		none	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Solomon - Crum			Alice - Hahn								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
no			212-38-9929			Springfield Hospital records, Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute renal failure</u>										Day	
2509 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal disease (diabetic)</u>										years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic brain syndrome with CVA with behavioral reaction.</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>1/15/</u> , 19 <u>69</u> , to <u>3/12/</u> , 19 <u>69</u> , that <del>he</del> (we) last saw the deceased alive on <u>3/12/</u> , 19 <u>69</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED								
Balbir Singh M.D.			3/12/69								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Balbir Singh, M.D.			Springfield State Hospital Sykesville, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			3/15/69			Mt. Hope Cem.			Woodsboro Fred. Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
			21793			MAR 17 1969			Charles Yude		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03720



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03747		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		03741	
Item#5, Film G411		4/7/69 km		CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or print) First Middle Last Mary Alice Lockard			2a. DATE OF DEATH Month Day Year 3 25 69		2b. HOUR 3:55 A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH 1895 March 28, 1941		6. AGE (In years last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Frederick Co.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll County Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Reisterstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 119 Glyndon Drive
14. FATHER'S NAME First Middle Last Samuel T. Brandenburg		15. MOTHER'S MAIDEN NAME First Middle Last Susan E. Gaver			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 213-34-0878A	17. INFORMANT Address Mr. Austin M. Brandenburg Balto. Md. 21207		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC MELANOMA 1729 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 mo.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 3/18, 1969, to 3/25, 1969, that (I) (we) last saw the deceased alive on 3/25/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Vincent J. Francis, M.D.		22c. DATE SIGNED 3/25/69		22d. PHYSICIAN'S NAME (Type) 22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 28, 69	23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery		23d. LOCATION (City or Town) (County) (State) Reisterstown, Md.
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown Md.			25a. REC'D BY REGISTRAR DATE APR 1 1969		25b. REGISTRAR'S SIGNATURE William A. Under

0374

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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03748

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03742

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First May	Middle -	Lost Longnecker	2a. DATE OF DEATH 3 Month 11 Day 69 Year		2b. HOUR 7:30 am				
3. SEX female		4. RACE white		5. DATE OF BIRTH 5/14/77		6. AGE (In years last birthday) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll		Md.			
10. CITY OR TOWN OF DEATH Rural--Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurses Aide		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Clarksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Route #1			
14. FATHER'S NAME First Lyde		Middle -		Last Watkins		15. MOTHER'S MAIDEN NAME First Mandy		Middle -		Last Phillips	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 219-03-6757		17. INFORMANT Address Springfield Hospital records, Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/18/1966</u> , to <u>3/11/1969</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>3/11/1969</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.											
22b. SIGNATURE <u>[Signature]</u>		22c. DATE SIGNED 3/11/69		22d. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M. D.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3-18-69		23c. NAME OF CEMETERY OR CREMATORY Wesley Hudson Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville, Md.		25a. REC'D BY REGISTRAR DATE MAR 18 1969			
24. FUNERAL DIRECTOR Name W. Hight		Sykesville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge							

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03749

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>CARL</b>			First Middle Last			2a. DATE OF DEATH Month <b>3</b> Day <b>23</b> Year <b>1969</b>			2b. HOUR <b>2:39</b> M		
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>March 31, 1908</b>			6. AGE (In years last birthday) <b>60</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH <b>Carroll Co.</b>		
10. CITY OR TOWN OF DEATH <b>Westminster</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Co. Gen. Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>			13c. CITY OR TOWN <b>Finksburg</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME <b>Conrad H. Ludwig</b>			15. MOTHER'S MAIDEN NAME <b>Elizabeth A. Schmidt</b>			13e. STREET AND NUMBER <b>Rt # 1</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>218-07-3521</b>			17. INFORMANT <b>Paul C. Ludwig</b>			Address <b>8456 Loch Raven Blvd. 21204</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Vascular Heart Disease</b> <b>4249</b> DUE TO, OR AS A CONSEQUENCE OF Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b> <b>1 year</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Arthritis Spine Several yrs.</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>July 22, 1962</b> to <b>March 23, 1969</b> , that (I) (we) last saw the deceased alive on <b>March 21, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W. Glenn Speicher</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>3-23-69</b>		
22d. PHYSICIAN'S NAME (Type) <b>W. GLENN SPEICHER MD</b>						22e. ADDRESS <b>135 EAST MAIN ST WESTMINSTER MD 21157</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>3/25/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>St. Matthews</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>		
24. FUNERAL DIRECTOR <b>Wm. E. Johnson</b>						ADDRESS <b>8521 Loch Raven Blvd. 21204</b>			25a. REC'D BY REGISTRAR <b>MAR 26 1969</b>		
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03750

CERTIFICATE OF DEATH

03744

1. DECEASED-NAME (Type or print)			First LUTHER	Middle M.	Last MCDONOUGH	2a. DATE OF DEATH Month Day Year MARCH 28 19 69			2b. HOUR 6:14		
3. SEX male		4. RACE white		5. DATE OF BIRTH April 23, 1898		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 306 Carroll Ave				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Miller		12b. KIND OF BUSINESS OR INDUSTRY Milling			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 306 Carroll Ave.,			
14. FATHER'S NAME First Middle Last Luther C. McDonough			15. MOTHER'S MAIDEN NAME First Middle Last Mary Remick								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) -----		17. INFORMANT Address Mrs. Daisy McDonough same							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of prostate - generalized metastases</u> 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from 1/10, 19 67, to 3/28, 19 69, that (I) (we) last saw the deceased alive on 3/26, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE James P. Kerr M.D.						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/28/69			
22d. PHYSICIAN'S NAME (Type) JAMES P. KERR						22e. ADDRESS DAMASCUS, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3-31-1969		23c. NAME OF CEMETERY OR CREMATORY Pine Grove		23d. LOCATION (City or Town) (County) (State) Mt. Airy, Md.					
24. FUNERAL DIRECTOR C.M. Waltz, Box 241, Sykesville, Md.						25a. REC'D BY REGISTRAR DATE APR 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03751

CERTIFICATE OF DEATH

03745

1. DECEASED-NAME (Type or print) <b>ANNIE</b> First Middle Last		2a. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1969</b>		2b. HOUR <b>12:15 PM</b>
3. SEX <b>Female</b>	4. RACE <b>Cau.</b>	5. DATE OF BIRTH <b>November 6, 1892</b>	6. AGE (In years last birthday) <b>76 YRS.</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Carroll</b> Md.	
10. CITY OR TOWN OF DEATH <b>Westminster</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll County Gen. Hosp.</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Hampstead</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>North Main Street</b>
14. FATHER'S NAME First Middle Last <b>Lawrence Snyder</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>Amelia Utz</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) <b>NO</b> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <b>220-46-3516</b>	17. INFORMANT Address <b>Robert E. Murray Hampstead, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis due to ruptured sigmoid colon</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1533 Adenocarcinoma - sigmoid colon</b> (b) <b>Adenocarcinoma - sigmoid colon</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arterio-sclerotic heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>				
19a. DATE OF OPERATION <b>3/16/69</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal obstruction</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>3/14</b> , 19 <b>69</b> , to <b>3/23</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/23</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Richard Y. Dalrymple</b>	22c. DATE SIGNED <b>3/23/69</b>	22d. PHYSICIAN'S NAME (Type) <b>RICHARD Y. DALRYMPLE</b>		
22e. ADDRESS <b>187 E. MAIN ST WESTMINSTER, MD</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/26/69</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Marks Church Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Snydersburg Carroll Md.</b>	
24. FUNERAL DIRECTOR <b>John E. Hoff</b>	25a. REC'D BY REGISTRAR <b>324 N. Main Street Hampstead, Maryland</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	DATE <b>MAR 26 1969</b>	



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UNITED STATES OF AMERICA

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D.C.

[The main body of the document contains several paragraphs of text that are extremely faint and illegible. The text appears to be a formal report or memorandum, possibly detailing military operations or administrative matters. The layout includes a header section, a main body with multiple paragraphs, and a footer section. The text is oriented horizontally across the page.]

[The footer section of the document contains additional text, which is also faint and illegible. It likely includes a date, a signature line, and possibly a reference number or classification marking.]



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03752

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03746

1. DECEASED NAME (Type or Print) <b>CHARLES OTTO MYERS SR</b>			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year <b>3-29 1969</b>			2b. HOUR <b>?</b> M <b>M</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>APRIL 23, 1887</b>		6. AGE (In years last birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>CARROLL CO.</b>		
10. CITY OR TOWN OF DEATH <b>FRIZZELBURG</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTMINSTER RT#7</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>CARROLL</b>			13c. CITY OR TOWN <b>WESTMINSTER</b>			13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
14. FATHER'S NAME <b>CHARLES W. MYERS</b>			15. MOTHER'S MAIDEN NAME <b>CLARA OTTO</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>215-32-7405A</b>		
17. INFORMANT <b>CHARLES O. MYERS, JR.</b>			ADDRESS <b>WARD AVE. WESTMINSTER</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (acute)</b> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>W. E. Spencer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>3-29-69</b>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>4/1/69</b>				23c. NAME OF CEMETERY OR CREMATORY <b>MEADOWBRANCH CEM.</b>			
24. FUNERAL DIRECTOR <b>J. E. Myers, Jr.</b>				ADDRESS <b>Westminster, Md.</b>				25a. REC'D BY REGISTRAR <b>APR 2 1969</b>			
								25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>			

03523

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

03753		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03747	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print) First Middle Last Maude Stem Nusbaum				2a. DATE OF DEATH Month Day Year Mar 10 1969		2b. HOUR 7:42 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH UNKNOWN		6. AGE (In years lost birthday) ESTIMATED 87 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.	
10. CITY OR TOWN OF DEATH New Windsor		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RFD Boarding Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD 1	
14. FATHER'S NAME First Middle Last Joseph Stem				15. MOTHER'S MAIDEN NAME First Middle Last Charlotte Wilt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 219-12-2336		17. INFORMANT Address THOMAS STEM SYKESVILLE RURAL MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic CVD</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Carcinoma stomach</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1969</u> , to <u>3/10/69</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>3/19/69</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) (did not) view the body after death.							
22b. SIGNATURE <u>M. E. Robertson MD</u>				22c. DATE SIGNED 3/10/69		22d. PHYSICIAN'S NAME (Type) M. E. Robertson	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/12/69		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) New Windsor Frederick Carroll Md.	
24. FUNERAL DIRECTOR ADDRESS <u>JD Hertzler &amp; Sons New Windsor</u>				25a. REC'D BY REGISTRAR DATE MAR 15 1969		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

03753

DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS  
BUREAU OF VITAL RECORDS

DATE

TIME

PLACE

NAME

SEX

AGE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03754					03748				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last John NMN Offutt					Month Day Year 3 9 69			7:55 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Negro		22 12/16/1873?		96?950.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield State Hosp.		??		??			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montg.		Bethesda				5063 River Road	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last				
Thomas F Offutt					Mollie ?? Combash				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
unknown		220-54-5270T		and Son George Offutt		Hospital records 3800 - 14th ST NW			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									
4123 DUE TO, OR AS A CONSEQUENCE OF <u>Chronic Heart failure</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Heart failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Coronary atherosclerotic Heart Disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
CBS associated with senile brain disease without qualifying phrase									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I (this hospital) attended the deceased from 12/16, 1965, to 3/9, 1969, that I (we) last saw the deceased alive on 3/9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
Gracito V. Patricio		3/9/69		Gracito V. Patricio					
22e. ADDRESS		22f. ADDRESS							
Springfield State Hospital, Sykesville, Md		Springfield State Hospital, Sykesville, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		3-15-69		HARMONY MEM. PT		LANDOVER PR. GEO. MD			
24. FUNERAL DIRECTOR		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
J. H. Taylor		3821 14th ST. N.W.		MAR 19 1969		Charles Judge			

03754

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03755

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03749

1. DECEASED-NAME (Type or print) <i>Ella</i> First <i>Blanche</i> Middle <i>Peltzer</i> Last			2a. DATE OF DEATH Month <i>March</i> Day <i>26</i> Year <i>1969</i>			2b. HOUR <i>9:30</i> P.M.	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>March 4, 1884</i>		6. AGE (In years last birthday) <i>85</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Carroll Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i> Md.	
10. CITY OR TOWN OF DEATH <i>Mt. Airy</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Rt 2 Box 105</i>		12a. USUAL OCCUPATION (Kind of work done during last year, if even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Mt. Airy</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>Rt 2 Box 105</i>		14. FATHER'S NAME First <i>William</i> Middle <i>H.</i> Last <i>Powder</i>		15. MOTHER'S MAIDEN NAME First <i>Martha</i> Middle <i>A.</i> Last <i>Wampler</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>217-48-7042</i>		17. INFORMANT <i>Mr. Herman C. Powder</i>		Address <i>Mt. Airy, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1952</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov. 1961</i> , to <i>March, 1969</i> , that (I) (we) last saw the deceased alive on <i>March 25, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>W.B. Culwell</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>March 26, 1969</i>	
22d. PHYSICIAN'S NAME (Type) <i>W.B. Culwell</i>				22e. ADDRESS <i>900 So Main St Mt Airy, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>March 29, 69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Reisterstown Methodist</i>		23d. LOCATION (City or Town) (County) (State) <i>Reisterstown, Md.</i>	
24. FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons Reisterstown, Md.</i>				25a. REC'D BY REGISTRAR <i>APR 1 1969</i>		25b. REGISTRAR'S SIGNATURE <i>G. Charles Judge</i>	

7250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

03756				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03750			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <i>William C. Phillips</i>				2a. DATE OF DEATH Month <i>March</i> Day <i>17</i> Year <i>1969</i>				2b. HOUR <i>9:35</i> M			
3. SEX <i>Male</i>		4. RACE <i>White-Cauc.</i>		5. DATE OF BIRTH <i>Sept. 27, 1885 ?</i>		6. AGE (In years last birthday) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>CARROLL</i> Md.					
10. CITY OR TOWN OF DEATH <i>WESTMINSTER</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Westminster Boarding Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>CARROLL</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First <i>Louis</i> Middle <i>Phillips</i> Last <i>Baker</i>		15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i> Middle <i>Baker</i> Last <i>Baker</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>218-52-2941</i>		17. INFORMANT Name <i>Mrs. Hilda W. Wainwright</i> Address <i>Sumner Road, Westminster, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4109</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>7-1</i> , 19 <i>67</i> , to <i>17 March 19 69</i> , that (I) (we) last saw the deceased alive on <i>17 March 19 69</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Dean A. Sniff, M.D.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>17 March 69</i>					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS <i>19 Ridge Rd., Westminster, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>3/20/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Deer Park Meth. Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Amesbury, Carroll, Md.</i>					
24. FUNERAL DIRECTOR <i>E. S. Myers, Jr., Westminster, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>MAR 19 1969</i>		25b. REGISTRAR'S SIGNATURE					

03756

MINISTRY OF HEALTH

03756

RECEIVED  
10/10/54

CHIEF  
MEDICAL  
OFFICER



10/10/54

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV. 11/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03757										
03751										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>Rhoda W Rickell</i>					2a. DATE OF DEATH <i>March</i> Month <i>Day</i> <i>15</i> Year <i>1969</i>			2b. HOUR <i>6:30</i> A M		
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>July 12, 1901</i>		6. AGE (In years last birthday) <i>67</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Carroll Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i> Md.				
10. CITY OR TOWN OF DEATH <i>Manchester, Md</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Longview Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>			13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>RFD #5 Box 330</i>	
14. FATHER'S NAME First Middle Last <i>Columbus Wagner</i>					15. MOTHER'S MAIDEN NAME First Middle Last <i>Slone</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>			16b. SOCIAL SECURITY NO. <i>213-05-1257</i>		17. INFORMANT (Last name) Address <i>Adam T. Rickell Westminster, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Convulsions.</i> <i>174X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Primary Carcinoma of Left Breast</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>March 11, 1969</i> , to <i>March 15, 1969</i> , that (I) (we) lost saw the deceased alive on <i>March 14, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Joseph E. Bush</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3/15/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>						22e. ADDRESS <i>Hampstead Maryland</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>3/19/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Johns Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Westminster Carroll, Md.</i>			
24. FUNERAL DIRECTOR <i>J.E. Myers, Jr., Westminster, Md.</i>						25a. REC'D BY REGISTRAR DATE <i>MAR 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

03580

REMARKS OF CREW

WIND DIRECTION AND FORCE, SEA, CLOUDS, VISIBILITY, etc.

0115



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 18- Film 422 3-20-70am										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03758										
CERTIFICATE OF DEATH										
03752										
1. DECEASED-NAME (Type or print) First Middle Last RICHARD (NMN) ROBERTS					2a. DATE OF DEATH Month Day Year March 19, 1969			2b. HOUR 6:55 P.M.		
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 12-25-1886			6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.				
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Mechanic (retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Prince George's		13c. CITY OR TOWN Landover		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 6620 Deputy Lane		
14. FATHER'S NAME First Middle Last Henry Roberts			15. MOTHER'S MAIDEN NAME First Middle Last Sylvia Roberts							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Address Records, Springfield State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Moderately advanced pulmonary tuberculosis, inactive, with effusion</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>10-31-68</u> , 19____, to <u>3-19-69</u> , 19____, that (I) (we) last saw the deceased alive on <u>3-19-69</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Rene G. Llera, M. D.					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-19-69	
22d. PHYSICIAN'S NAME (Type) Rene Llera, M. D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-24-69		23b. DATE			23c. NAME OF CEMETERY OR CREMATORY Harmony		23d. LOCATION (City or Town) (County) (State) Highland Park Md			
24. FUNERAL DIRECTOR H.S. Washington & Son 1425 Deane Ave					ADDRESS D.C.		25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

8708

UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

035580

DATE

TO

FROM

SUBJECT

REMARKS

INITIALS

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TIME

LOCATION

PROPERTY OF

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BY

FOR

REASON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03759		CERTIFICATE OF DEATH						03753			
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Hirsch (NMN) Rosenberg						March Month 4 Day 1969 or			8:45A.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		White		5-29-29		39 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Maryland		U.S.A.				Carroll					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			Odd Jobs					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Balto. City		Baltimore				2008 Maryland Avenue		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Harry Rosenberg			Ginnie Brown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
Yes			212-26-2344			HEBREW FREE BURIAL SOCIETY			Address MOSE MORRIS 100 MARKET		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										PL	
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>										Weeks	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
CBS, Huntington's chorea, with psychotic reaction											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>12-15-64</u> , to <u>3-4-</u> , 1969, that (I) (we) last saw the deceased alive on <u>3-4-19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
		3-4-69									
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
Octavio A. Ruiz, M.D.					Springfield State Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
BURIAL		3-10-69		OHEB SHALOM			BALTIMORE, MARYLAND				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD					MAR 13 1969						

03750

03750

UNITED STATES ARMY  
POST OFFICE BOX 1000  
FORT MONMOUTH, NEW JERSEY 08041

UNITED STATES ARMY  
POST OFFICE BOX 1000  
FORT MONMOUTH, NEW JERSEY 08041

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03760

CERTIFICATE OF DEATH

03754

1. DECEASED-NAME (Type or print) <b>AUGUST GEORGE SANDROCK</b>			2a. DATE OF DEATH 3 Month 8 Day 69 Year			2b. HOUR 2:30 P.M.			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JUNE 15-1877</b>		6. AGE (In years lost birthday) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b>			
10. CITY OR TOWN OF DEATH <b>NEW WINDSOR</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HORTONS BOARDING HOME</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STATE ROADS</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>HARFORD</b>		13c. CITY OR TOWN <b>BELAIRE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>UNKNOWN</b>	
14. FATHER'S NAME First Middle Last <b>JUSTUS SANDROCK</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>CHRISTINA SHROEDER</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>214-16-3453</b>		17. INFORMANT Address <b>MRS WM LAWSON GLYNDON MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C.V.D.</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 13, 1943</b> , to <b>3/8, 1949</b> , that (I) (we) lost saw the deceased alive on <b>3/5/49</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>M. E. Robertson MD</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3/8/49</b>	
22d. PHYSICIAN'S NAME (Type) <b>M E ROBERTSON</b>				22e. ADDRESS <b>New Windsor Rd. 21774</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>3/11/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST PAULS</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MD</b>			
24. FUNERAL DIRECTOR <b>D D Hartzler &amp; Sons</b>				ADDRESS <b>New Windsor</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 11 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

08760

REPUBLIC OF GUATEMALA

08760



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 151  
304 REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03761									
03755									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Annie			- Sedlacek			3 Month 6 Day 69 Year			2:40 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
female		white		unknown		82? YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Bohemia		Bohemia				Carroll Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Rural--Sykesville		Springfield State Hospital		seamstress					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		-		Baltimore				2018 Ellsworth St.	
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last
William			- Sedlacek			Annie			- Laznicka
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no		220-54-7136T		Springfield Hospital records, Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Septecemia									days
DUE TO, OR AS A CONSEQUENCE OF (b) Decubitus ulcers									weeks
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Schizophrenic reaction, paranoid type.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from 1/28/19 10, to 3/6/19 69, that (X) (we) last saw the deceased alive on 3/6/19 69, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Naci N. Buyukunsal, M. D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3/6/69		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Naci N. Buyukunsal, M. D.					Springfield State Hospital Sykesville, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		11 Mar 7/69		Bohemia A & L		Baltimore			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Philip Herwig Sons, Calverton, Md.					MAR 10 1969		Charles Judge		

03780

MAR 10 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
30M REV. 1-60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03762 CERTIFICATE OF DEATH 03756											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
MAUDE HENRIETTA SEIPP						Month	Day	Year	7:40 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR			
FEMALE		WHITE		FEB. 5, 1903		66 YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				CARROLL Co. Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
WESTMINSTER			CARROLL Co. GEN. HOSP.			HOUSE-WIFE					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MARYLAND			CARROLL		WESTMINSTER		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		195 WILLIS ST		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
JOHN T. LITTLE						SARAH REBECCA TAWNEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address
NO						218-32-1522		C. IVAN SEIPP			SAME ADDRESS
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 174X GENERALIZED METASTATIC DISEASE										MDS.	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) CARCINOMA OF BREAST - (L)										2 YEARS	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
CORONARY INSUFFICIENCY											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 3/12, 1969, to 3/13, 1969, that (I) (we) last saw the deceased alive on 3/13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
J. J. Proctor, M.D.						3/13/69					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL			3/15/69		EVERGREEN MEM. GARDENS		FINKSBURG CARROLL MD.				
24. FUNERAL DIRECTOR			ADDRESS		25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
J. S. Murrell, Westminster, Md.					MAR 17 1969			J. Charles Judge			

03780

UNITED STATES OF AMERICA

03780

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03763		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03757	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First OLIVE	Middle PEARL	Lost SINES	2a. DATE OF DEATH Mar Month 25 Day 1969 Year	
3. SEX FEMALE			4. RACE WHITE		5. DATE OF BIRTH JAN. 23, 1884		2b. HOUR 12 P M
6. AGE (In years last birthday) 85 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) WILMINGTON DEL.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Co. Md.
10. CITY OR TOWN OF DEATH WESTMINSTER			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. GEN. HOSP			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSE-WIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last JAMES ALBERT KNIGHT			15. MOTHER'S MAIDEN NAME First Middle Last LAURA JANE SNYDER		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		
16b. SOCIAL SECURITY NO. 220-54-8950-4			17. INFORMANT Address 2617 PROCTOR LANE MRS. ROBT. F. ROGGE, BALTO. MD 21234				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral arteriosclerosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Mar 22, 1969, to Mar 23, 1969, that (I) (we) last saw the deceased alive on Mar 23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE John S. Harshey, MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/25/69	
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY MD		22e. ADDRESS 504 W. S. HARSHEY RD		22f. ADDRESS 8 arden st. Westminster, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 3/28/69		23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH CEM.		23d. LOCATION (City or Town) (County) (State) WESTMINSTER RD. Md.	
24. FUNERAL DIRECTOR J.S. Myers, Jr. Westminster, Md.		25a. REC'D BY REGISTRAR DATE MAR 28 1969		25b. REGISTRAR'S SIGNATURE John S. Harshey			

03162

RECEIVED TO - JANUARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03764					03758					
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH					
First <b>ANNA</b>					Month <b>3</b> Day <b>25</b> Year <b>69</b>					
3. SEX <b>Female</b>					4. RACE <b>White</b>					
5. DATE OF BIRTH <b>Nov. 9, 1906</b>					6. AGE (In years last birthday) <b>62</b> YRS.					
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>Carroll</b>					
10. CITY OR TOWN OF DEATH <b>Westminister</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Co. Gen. Hosp.</b>					
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>					12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>					13b. CITY OR TOWN <b>Westminister</b>					
13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					13d. STREET AND NUMBER <b>Rt #4 Box 265A Westminister</b>					
14. FATHER'S NAME First <b>Paul</b> Middle <b>Simon</b> Last <b>Simon</b>					15. MOTHER'S MAIDEN NAME First <b>Johanna</b> Middle <b>?</b> Last <b>?</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <b>no</b> (If yes give war or dates of service)					16b. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>Adolf Staub</b>					Address <b>Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b>										
DUE TO, OR AS A CONSEQUENCE OF										
(b) <b>ABCESS OF LEFT FOOT</b>										
DUE TO, OR AS A CONSEQUENCE OF										
(c) <b>GOUTY ARTHRITIS</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
<b>BLEEDING PEPTIC ULCER</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/22, 1969</b> , to <b>3/25, 1969</b> , that (I) (we) last saw the deceased alive on <b>3/25, 1969</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Thurmond J. Brown Jr. MD</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>3/25/69</b>		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>3/28/69</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Gardens Of Faith</b>			23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>Leonard J Ruck Inc Baltimore, Maryland</b>						25a. REC'D BY REGISTRAR <b>MAR 26 1969</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Judge</b>		

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RECORD OF DEEDS

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
ROBERT LEROY STERN						ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 3-19 1969		6:30 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	Nov. 22, 1913	55 YRS.	MONTHS DAYS	HOURS MIN.	Month 3 Day 19 Year 1969		8:15 A.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Carroll Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Rural-Finksburg			Route 2			Well-driller			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland			Carroll			Finksburg		Route 2	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last Walter A. Stern			First Middle Last Stella Edmondson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS	
No			219-14-1071			Mrs. Stella Stern		Same As #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis (Sudden)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			3-19-69			
Dr. W. Glenn Speicher			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			135 E. Main St. West Chester, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	
Burial		3/22/1969		Lakeview Memorial Park		Carroll, Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
C.M. Waltz, Box 241, Sykesville, Md.						MAR 24 1969		J. W. G. Gage	

0350

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03766

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03760

1. DECEASED-NAME (Type or Print) <b>LEVOLA JANE WARD TAYLOR</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>3</b> Day <b>4</b> Year <b>1969</b>			2b. HOUR <b>7:33</b> M <b>P</b>		
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>SEPT, 11, 1884</b>	6. AGE (In years last birthday) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS <b>7</b> DAYS <b>1</b>	IF UNDER 24 HRS. HOURS <b>7</b> MIN. <b>33</b>	2c. DATE PRONOUNCED DEAD Month <b>3</b> Day <b>4</b> Year <b>1969</b>		
7a. BIRTHPLACE (State or foreign country) <b>CARROLL</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO.</b>		
10. CITY OR TOWN OF DEATH <b>FINKSBURG RD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ROUTE #140</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSE WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>FINKSBURG</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>SANDY MOUNT</b>
14. FATHER'S NAME First <b>ALFRED</b> Middle <b>WARD</b> Last <b>WARD</b>			15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>JANE</b> Last <b>BARNES</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-20-7002</b>		17. INFORMANT ADDRESS <b>MRS. WILLIAM E. PRICE, FINKSBURG, MD</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull &amp; multiple injuries</b> <b>8147</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>—</b> (b) <b>—</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <b>3-4 1969</b> HOUR A.M. <b>7:33</b> P.M. <b>—</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 2, Item 18.) <b>Fallen in front of tractor trailer</b>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Old Bull Rd &amp; Route 112 mi East Finksburg Carroll MD</b>		21f. LOCATION Street or R.F.D. No. <b>—</b> City or Town <b>—</b> County <b>Carroll</b> State <b>MD</b>		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE <b>W. L. Speicher</b>		EXAMINER'S NAME (Type) <b>—</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>3-4-69</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>3/7/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN CEMETERY</b>		23d. LOCATION (City or Town) (County) <b>GETTYSBURG PENNA</b>		
24. FUNERAL DIRECTOR <b>J. S. Myer, Jr., Westminster, Md.</b>				25a. REC'D BY REGISTRAR <b>—</b> DATE <b>MAR 10 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

03766

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03766

SECTION OF EXAMINER GENERAL'S OFFICE

SECTION OF EXAMINER GENERAL'S OFFICE

MAR 10 1969



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03767 CERTIFICATE OF DEATH 03761									
1. DECEASED-NAME (Type or print) First Middle Last <b>Delaney Hanson White</b>					2a. DATE OF DEATH Month Day Year <b>3 2 69</b>		2b. HOUR <b>5:54A</b>		
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>11-23-40</b>		6. AGE (In years last birthday) <b>28</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.			
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>515 Bloom</b>	
14. FATHER'S NAME First Middle Last <b>Alfred White</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Louise Talafaro</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-38-2425</b>		17. INFORMANT <b>Springfield State Hosp. Records</b>		Address <b>Sykesville Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> <b>5710</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Portal Cirrhosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>  <b>mo. or yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Alcoholism (Addiction)</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>2-28-69</b> , 19____, to <b>3-2-69</b> , 19____, that (I) (we) last saw the deceased alive on <b>3-2-69</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gracito X. Patricio</b>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>3-2-69</b>		
22d. PHYSICIAN'S NAME (Type) <b>Gracito X. Patricio, M.D.</b>					22e. ADDRESS <b>Sykesville, Maryland 21784</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-6-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. AUBURN CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTO. Md.</b>			
24. FUNERAL DIRECTOR <b>D.R. Bailey-Kelson F.N.</b>					25a. REC'D BY REGISTRAR <b>DATE MAR 5 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Yung</b>		

03787

UNITED STATES OF AMERICA

03787



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03768					03762				
1. DECEASED-NAME (Type or print) First Middle Last <b>Annie (NMN) Williams (Harris)</b>					2a. DATE OF DEATH Month Day Year <b>3-1-69</b>			2b. HOUR <b>6:10a M</b>	
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>8-13-1884</b>		6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>u.s.a.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.			
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield St. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Balto. City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2536 Madison Ave.</b>	
14. FATHER'S NAME First Middle Last <b>John Harris</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Temperance Simms</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>2 17-30-4240-A</b>		17. INFORMANT Address <b>Springfield St. Hosp. Records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral confluent broncho-pneumonia.</b> <b>485X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CBS with senile brain disease, with psychotic reaction.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>2-17-66</b> , 19____, to <b>3-1-69</b> , 19____, that (I) (we) last saw the deceased alive on <b>3-1-69</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. Antonius Glahn</b>				22c. DATE SIGNED <b>3-1-69</b>		22d. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M.D.</b>			
22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3-5-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Meth. Ch. Cem. Lothian, Maryland</b>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>				25. REC'D BY REGISTRAR <b>MAR 4 1969</b>		26. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

03783

CENTRAL BANK OF AMERICA

IN THE CITY OF NEW YORK

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03769

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03763

1. DECEASED-NAME (Type or print) First Middle Last CHARLES WILLIAM WILSON			2a. DATE OF DEATH Month Day Year MARCH 17, 1969			2b. HOUR 3:05 PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5-2-1892		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bartender (retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rural		
14. FATHER'S NAME First Middle Last Thomas J. Wilson			15. MOTHER'S MAIDEN NAME First Middle Last Liddie Ruck								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown)) Unk.			16b. SOCIAL SECURITY NO. 214-09-2805		17. INFORMANT Address Records, Springfield State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of right bronchus with metastases to right lung 1621 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma of liver DUE TO, OR AS A CONSEQUENCE OF (c) Abscess & empyema, right lung and pleura								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months Months Weeks			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 8-5-68, 19, to 3-17-69, 19, that (I) (we) last saw the deceased alive on 3-17-69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Octavio A. Ruiz, M.D.						DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 3-21-69	
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.						22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-22-69		23c. NAME OF CEMETERY OR CREMATORY Wesley Freedom Cemetery			23d. LOCATION (City or Town) (County) (State) Sykesville Md.				
24. FUNERAL DIRECTOR Harry W. Haight				ADDRESS Sykesville, Md.		25a. REC'D BY REGISTRAR MAR 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

03789



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MUMBAI





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03770

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

03764

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month <u>Mar</u> Day <u>27</u> Year <u>1969</u>		2b. HOUR <u>3 P</u> M	
EDNA		R.		WRIGHT				
3. SEX Female		4. RACE White		5. DATE OF BIRTH Nov. 12, 1902		6. AGE (In years last birthday) 66 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll, Md.		
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. General Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME Emory		15. MOTHER'S MAIDEN NAME Ellsworth Dayhoff		16. SOCIAL SECURITY NO. 220-01-6609A		17. INFORMANT Mr. Edward A. Wright		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 220-01-6609A		17. INFORMANT Mr. Edward A. Wright		17. ADDRESS Same As #13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>4339</u> IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 27, 1969</u> , to <u>Mar 27, 1969</u> , that (I) (we) lost saw the deceased alive on <u>Mar 27, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>John S. Harshey, MD</u>		22c. DATE SIGNED <u>3/27/69</u>		22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, MD				
22e. ADDRESS <u>8 Anchor St Westminster, Md</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3/30/1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Locust Grove Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Carroll, Md.</u>		
24. FUNERAL DIRECTOR <u>C. M. Waltz, Box 241, Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 1 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

NOTED

NOTED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03771		CERTIFICATE OF DEATH						03765			
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
SAMUEL HERBERT			Yingling			Month Day Year 3 13 69			9P M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		11-8-1888			80 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland		USA					Carroll Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
MANCHESTER			LONGVIEW NURSING HOME			CARPENTER			General		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			CARROLL		WESTMINSTER		YES		190 E Green		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
FRANCIS			YINGLING			ANNA			HARRY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			
NO			218-05-7817		LILLIAN M. YINGLING			WESTMINSTER MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Chronic hypertension											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) Arteriosclerosis Cerebrovascular Disease											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Primary Cerebral Hemorrhage & Secondary Metastases											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Feb 7, 1968, to March 13, 1969, that (I) (we) last saw the deceased alive on March 12, 1969, and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
Joseph E. Bush MD		3-13-69									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Joseph E. Bush MD		Hampstead Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		3/16/69		PROVIDENCE CEM.		GAMBER CARROLL MD.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REG. REGISTRAR		25b. REGISTRAR'S SIGNATURE					
J. E. Myers, Jr.		Westminster, Md.		MAR 17 1969		J. E. Myers, Jr.					

03771

UNIT OF PLAN

03772

CHARLES HERBERT 13 15 49

W.B. Jr 11-5-1887 20

MARY WARD USA Connell

MANCHESTER LAWRENCE ALFRED HARRIS GARROSTER

Weyford CARROLL WESTMINSTER 1905 Green

FRANCIS Xue Ling ARMY HARRY

NO 218-02-2511 LAMAR M Xue Ling WESTMINSTER

Chinese hypodermis  
Chinese to Chinese

Group Government of Chinese Foreign Relations

X

Group of 12 19 1913 19

Joseph E. Davis and Harriet E. Davis 3-12-19

WESTMINSTER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03772

CERTIFICATE OF DEATH

03766

1. DECEASED-NAME (Type or print) <b>LILLIE M. ZIEGLER</b>			2a. DATE OF DEATH Month <b>MARCH</b> Day <b>18</b> Year <b>1969</b>		2b. HOUR <b>9 P M</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>11-3-1884</b>		6. AGE (In years last birthday) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>York Pa</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Carroll</b>		
10. CITY OR TOWN OF DEATH <b>Manchester</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hung View Nursing Home</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>Parham Ave 3400</b>	
14. FATHER'S NAME First <b>Daniel</b> Middle <b>Springer</b> Last <b>Euphemia</b>	15. MOTHER'S MAIDEN NAME First <b>Wolfe</b> Middle <b>Wolfe</b> Last <b>Wolfe</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO. <b>MA 494243</b>	17. INFORMANT <b>Janet Maaser 2721 Alden Rd Baltimore Md 21234</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> <b>4369</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>generalized arteriosclerosis</b> 5 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) <b>last.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>19 MONTH</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/19</b> , 19 <b>67</b> , to <b>3/18</b> , 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>3/5</b> , 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>W. H. Foard</b>	DEGREE <b>MD.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>3/18/69</b>		
22d. PHYSICIAN'S NAME (Type) <b>W. H. Foard</b>	22e. ADDRESS <b>MANCHESTER, MD 21102</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/21/69.</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 20 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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Handwritten notes and stamps, including a circular stamp with a star and the word "RECEIVED".

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